MEDICAL BOARD OF CALIFORNIA
MEDICAL CONSULTANT PROGRAM

ORIGINAL APPLICATION

Name:_____,_____ _____
(Last) (First) (MI)

Address: _____ / _____
(No. & Street) (City/State/Zip Code)

Direct Phone & extension: _____ Other #: _____
(Please identify work, cell, etc.).

Date of Birth: _____ Email address: _____

Best way to be contacted: _____

Application Guidelines for Acceptance

(Please check all that apply)

- ❑ Currently Licensed and in good standing with the Medical Board of California

  License numbers(s) _____ _____ _____

- ❑ Retired (not more than 5 years)

- ❑ Board Certified (ABMS or any other non-ABMS certificates) - see page 4 for list

  Certificate Specialty: _____ Expiration Date _____

  _____ _____

  _____ _____

  Sub-Specialty: _____ Expiration Date _____

  _____ _____

  _____ _____

1. If you have retired from active medical practice, please indicate when you stopped practicing.

2. Describe your active medical practice or employment. (Active practice is defined as at least 80 hours per month in direct patient care or clinical activity or teaching, of which 40 hours must involve direct patient care.) Identify any special procedures (e.g., laporoscopic surgery) or modalities (e.g., alternative medicine) that you employ in your practice on the Practice Area Definers on page 4. Also, identify below any special training you have received that is not listed on page 1.

3. Describe any prior peer review experience (hospital, medical society, or equivalent).

4. Has any medical license board, other agency, or hospital (including the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity) filed or taken disciplinary action regarding any healing arts license which you now hold or ever held, for unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts, or malpractice?

   ❑ Yes ❑ No (If yes, see comments section to explain.)

5. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

   ❑ Yes ❑ No (If yes, see comments section to explain.)

6. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is an such action pending?

   ❑ Yes ❑ No (If yes, see comments section to explain.)

7. Have you ever been arrested, convicted, or pled *nolo contendere* to any violation of any federal, state, or local law of any state in the United States, or a foreign country? **You are required to list any conviction that has been set aside and dismissed or expunged, or where a stay of execution has been issued**.

❑ Yes ❑ No (If yes, see comments section to explain.)

Comments: _____

_____

_____

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PRIVACY NOTICE: ***The information provided on this application is maintained*** *by the Central Complaint Unit of the Medical Board of California (MBC), 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831, under the authority granted by the Business and Professions Code, Division 2, Chapter 5, Article 13, section 2332. It is mandatory that you provide all information requested. Omission of any information will result in the application being rejected as incomplete. Your completed application becomes the property of the MBC and will be used by the authorized personnel to determine your eligibility for participation in the Medical Consultant Program. Information on your application may be transferred to other governmental or law enforcement agencies. {You have the right to review the records maintained on you by the MBC unless the records are exempt from disclosure.]*

I hereby certify that all statements made in this application are true and complete, and I understand that any misstatements of material facts will subject me to disqualification. I have attached a current *curriculum vitae* to this application.

_____ _____

Signature Date

Mail completed application to:

_____

_____

_____

Medical Board of California
Medical Consultant Program
Attn: Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831

PRACTICE AREA DEFINERS

❒ ANESTHESIOLOGY
- ◯ Pain Management
- ◯ Other Related Practice(s): _____

❒ CARDIOLOGY
- ◯ Cardiovascular Disease
- ◯ Diagnostic Cardiology
- ◯ Non-interventional/non-invasive
- ◯ Other Related Practice(s): _____

❒ COMPLEMENTARY/ALTERNATIVE MEDICINE
- ◯ Other Related Practice(s): _____

❒ ENT-OTOLARYNGOLOGY
- ◯ Cosmetic Surgery
- ◯ Other Related Practice(s): _____

❒ FAMILY MEDICINE
- ◯ Other Related Practice(s): _____

❒ GENERAL MEDICINE/INTERNAL MEDICINE
- ◯ Allergy & Immunology
- ◯ Ambulatory Medicine
- ◯ Critical Care/Emergency Medicine/Urgent Care
- ◯ Dermatology
- ◯ Endocrinology
- ◯ Gastroenterology-Hepatology
- ◯ Geriatric Medicine
- ◯ Hematology/Oncology
- ◯ Hospice
- ◯ Infectious Diseases
- ◯ Nephrology
- ◯ Occupational Med. & Physical Medicine & Rehabilitation
- ◯ Pain Management
- ◯ Pulmonary Diseases
- ◯ Rheumatology
- ◯ Sports Medicine
- ◯ Other Related Practice(s): _____

❒ NEUROLOGY
- ◯ Neurological Surgery
- ◯ Neuropsychiatry
- ◯ Neurosurgery
- ◯ Other Related Practice(s): _____

❒ OB-GYN
- ◯ Endocrinology
- ◯ Gynecological Oncology
- ◯ High-Risk Pregnancies
- ◯ Infertility
- ◯ No Gyn
- ◯ No Obstetrics
- ◯ Other Related Practice(s): _____

❒ OPHTHALMOLOGY
- ◯ Cataracts
- ◯ Laser Surgery
- ◯ Lasik Surgery
- ◯ Vitreoretinal Surgery
- ◯ Other Related Practice(s): _____

❒ ORTHOPAEDICS
- ◯ Hand Surgery
- ◯ □ Shoulder, □ Knee, □ Hip, □ Other_____ , _____
- ◯ Pediatric Specialist
- ◯ Spinal Surgery
- ◯ Other Related Practice(s): _____

❒ PATHOLOGY
- ◯ Anatomic Pathology
- ◯ Bone Marrow Biopsy
- ◯ Forensic Pathology
- ◯ Blood Banking/transfusion Medicine
- ◯ Other Related Practice(s): _____

❒ PEDIATRICS
- ◯ Developmental-behavioral Pediatrics
- ◯ Neonatal-Perinatal Medicine
- ◯ Neurodevelopmental disabilities
- ◯ Pediatric Genetics
- ◯ Pediatric Hematology
- ◯ High Risk Deliveries/Pediatric Intensive Care
- ◯ Pediatric Infectious Diseases
- ◯ Other Related Practice(s): _____

❒ PLASTIC/RECONSTRUCTIVE SURGERY
- ◯ Facial
- ◯ Cosmetic Surgery
- ◯ Liposuction
- ◯ Other Related Practice(s): _____

❒ PSYCHIATRY
- ◯ Adult
- ◯ Addiction Medicine
- ◯ Child or Adolescent
- ◯ Medication Management
- ◯ Other Related Practice(s): _____

❒ RADIOLOGY
- ◯ Diagnostic Radiology
- ◯ Interventional Radiology
- ◯ Nuclear Medicine
- ◯ Neuroradiology
- ◯ Radiation Oncology
- ◯ Vascular Radiology
- ◯ Other Related Practice(s): _____

❒ SURGERY
- ◯ Cardiothoracic Surgery
- ◯ Cardiovascular Surgery
- ◯ Endoscopic Surgery
- ◯ Laparoscopic Surgery
- ◯ Pediatric Surgery
- ◯ Thoracic Surgery
- ◯ Trauma Surgery
- ◯ Vascular Surgery
- ◯ Other Related Practice(s): _____

❒ UROLOGY
- ◯ Other Related Practice(s): _____

	Yes	No
◗Do you supervise physician assistants?	◯	◯
◗Do you supervise nurse practitioners?	◯	◯
◗Do you have special training or use any procedure, practice modalities, etc., not listed?	◯	◯

If yes, please describe:

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